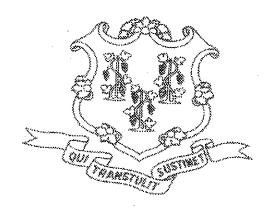
### **State of Connecticut**



### Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as	licensed)							
Universal Healthcare	Holdings LLC							
Address (No. & Stre	et, City, State, Z	Zip Code)						
5 Greenwood Street,	Hartford, CT 0	6106						
Type of Facility								
Chronic and C  Nursing Home	Convalescent e only (CCNH)		Rest Home with Supervision onl (RHNS)	_	•	(Specify)		
Report for Year Begin 10/1/2018	nning		Report for Year 9/30/2019	r Ending	**************************************			
				· · · · · · · · · · · · · · · · · · ·				
License Numbers:		CCNH 2541	RHNS		(Specify)			dicare Provider 07-5250A
Medicaid Provider N	umbers:	CC 2081	CNH	RI	HNS	· · · · · · · · · · · · · · · · · · ·	ICI	F-IID
For Department Us	e Only							
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence N Assigne		Signed as	nd Notarize	d	Date Received

### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Universal Healthcare Holdings LLC	2541	9/30/2019	1	37

### Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Universal Healthcare Holdings LLC [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Cori Knutsen	Plant		Printed Name (Owner) Chris Wright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Address of Notary Public				1 / /

(Notary Seal)

### **Table of Contents**

	eral Information - Administrator's/Owner's Certification	1
Gen	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gen	eral Information and Questionnaire - Type of Facility - Organization Structure	2
Gen	eral Information and Questionnaire - Partners/Members	3
Gen	eral Information and Questionnaire - Corporate Owners	3A
Gen	eral Information and Questionnaire - Individual Proprietorship	3B
Gen	eral Information and Questionnaire - Related Parties	4
Gen	eral Information and Questionnaire - Basis for Allocation of Costs	5
Gen	eral Information and Questionnaire - Leases	6
	eral Information and Questionnaire - Accounting Basis	7
	edule of Resident Statistics	8
Sche	edule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
<b>B</b> .	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
<u>C.</u>	Expenditures Other than Salaries - Administrative and General	15
<u>C</u> .	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C. C. C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
<u>C</u> .	Expenditures Other than Salaries (Cont'd) - Laundry	19
<u>C.</u>	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
<u>C</u> .	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
<u>C.</u>	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
<u>C</u> .	Expenditures Other than Salaries (Cont'd) - Interest	26
<u>C</u> .	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
<u>D</u> .	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
<u>H.</u>	Changes in Total Net Worth	36
<u>I.</u>	Preparer's/Reviewer's Certification	37

### State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1 <b>A</b>	37
Name of Facility		Period Cov	ered:	From	То
Universal Healthcare Holdings LLC				10/1/2018	9/30/2019
Address of Facility					
5 Greenwood Street, Hartford, CT 06106					
Report Prepared By		Phone Nun		Date	
iCare Management, LLC		860-570-23	140	2/15/2020	
Item		Total	CCNH	RHNS	(Specify)
		Total	CCIVII	KLIIVD	(Specify)
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

**DO NOT include Fringe Benefit Costs.** 

### **General Information and Questionnaire Type of Facility - Organization Structure**

		1	one No. of Fac	ility	Report for Ye	ar Ended	Page	of	Ī
		860	)-236-2901		9/30/2019		2	37	7
Name of Facility (as shown on license)			1		Street, City, Sto				
Universal Healthcare Holdings LLC		,		d Str	eet, Hartford, C	CT 06106			
T. 37	CCNH		RHNS		(Specify)		Medicare P	rovider	No.
License Numbers:	2541	<u> </u>					07-5250A		
Type of Facility (Check appropriate box(es))	)								
Chronic and Convalescent Nursing Home only (CCNH)			t Home with I pervision only			(Specify)			
Type of Ownership (Check appropriate box)	i								
O Proprietorship O LLC O	Partnership	0	Profit Corp.	0	Non-Profit Cor	р. О	Government	O Ti	'rust
If this facility opened or closed during report	year provide:			Date	e Opened	Date Clos	sed		
Has there been any change in ownership						<u> </u>			
or operation during this report year?		0	Yes	0	No	If "Yes,"	explain fully	r.	
Administrator									
Name of Administrator					Nursing Ho				
Cori Knutsen					Administrat	or's	2117		
					License 1	No.:			
Other Operators/Owners who are assistant ac	dministrators (	(full	or part time)	of thi	<del></del>				
Name					License N	No.:			
								Marie Add A	

### General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	Year Ended	Page of
Universal Healthcare Holdings	LLC	2541	9/30/2019		3 37
I INT CD	1: 47.0			1	or Town(s) in
Legal Name of Part		Business A			egistered
Universal Healthcare Holdings	LLC	5 Greenwood St Hartford, CT 06	•	СТ	
		liamora, Cr oo	100		
Name of Partners/Members	Business Ac	ddress		Title	% Owned
Creative Investment LLC	341 Bidwell Street, Ma 06040	nchester, CT	Member		45
Silver Investment LLC	341 Bidwell Street, Ma 06040	nchester, CT	Member		45
Vantage Capital Investors LLC	341 Bidwell Street, Ma 06040	inchester, CT	Member	100	8
Active Investments LLC	341 Bidwell Street, Ma 06040	nchester, CT	Member		1
B&M Advisors LLC	341 Bidwell Street, Ma 06040	nchester, CT	Member		1

### General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Yea	r Ended	Page	of
Universal Healthcare Holdings LLC	2541	9/30/2019		3 <b>A</b>	37
If this facility is owned or operated as a corpo	ration, provide t	the following inforr	nation:		
Legal Name of Corporation	Busi	iness Address	State(s) in W	hich Incorr	orated
				NI. C1	1
Name of Directors, Officers	Busi	iness Address	Title	No. SI	
				Held by	/ Each
The state of the s					
Names of Stockholders Owning at Least 10%					
of Shares					
		, , , , , , , , , , , , , , , , , , ,			
			<b>!</b>		

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Universal Healthcare Holdings LLC	2541	9/30/2019	3B	37
If this facility is owned or operated as an individua	al proprietorship,	provide the following inforr	nation:	
Ow	mer(s) of Facility	<u> </u>		
	-			
	***************************************			
				***************************************
		· · · · · · · · · · · · · · · · · · ·		
· • • • • • • • • • • • • • • • • • • •				
				w
			<u> </u>	
				· · ·
		**************************************		***

State of Connecticut Annual Report of Long-Term Care Facility CSP-4 Rev. 10/2005

254 Related Parties\*

Name of Facility		I icense No	No.		Seport for Year Ended		Dage	Jo
Universal Healthcare Holdings LLC	Holdings LLC	g .	22486		9/3/2019		4	37
	the throughout the same was the same and the							
		Als Good	Also Provides Goods/Services to	es to		Indicate Where Costs are Included		Actual Cost to the
Name of Related	Business	M-HON!	related r	SI III	Description of Goods/Services	in Annual Report	Cost	Related
Company	Address	Yes	ž	**%	Provided	Page # / Line #	Reported	Party
Bidwell Care Center,	333 Bidwell St. Manchester, CT 06040				Chared Employees			*
Chelsea Place Care	25 Lorraine St. Hartfor			<u> </u>	חומים בחוקונקיסים		***************************************	
Center, LLC	C1 06105				Shared Employees		<u>.</u>	-
Center, LLC	171 Main St. East Windsor, CT 06088			<b>J</b> 1	Shared Employees		-	ı
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			,	Shared Employees		,	1
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			1	Shared Employees		1,856	(1,856)
Meriden Care Center, LLC (Silver	33 Roy St. Meriden, CT		······					
Springs)					Shared Employees		10,527	(10,527)
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106			<i>3</i> ,	Shared Employees		47,289	(47,289)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040				Shared Employees		r	ı
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			- V3	Shared Employees		137	(137)
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067			- V2	Shared Employees		23,006	(23,006)
Universal Healthcare Holdings, LLC	5 Greenwood Street, Hartford, CT 06106			,	Shared Employees		t	1
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067			0,	Shared Employees			1
Elevate Counseling Services LLC	341 Bidwell St. Manchester, CT 06040			5,	Shared Employees		1	1
Touchpoints Therapy LLC	341 Bidwell St. Manchester, CT 06040				OT/PT/ST	13 5,8,10	278,055	(278,055)
Realty	N/A			144	Building Lease & Rent	22,22,27 10,9,14	194,672	(194,672)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			,=	iCare Helt-Legal, Postage, Emp Recruitment & Marketing	16, 15 M.E	16,809	(16,809)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040			- V2	Shared EEs not part of mgmt agmt		115,719	(115,719)
					Management Services, Direct	20 5j	132,048	(132,048)
				7	Management Services, Indirect	20 5j	18,484	(18,484)
					Management Services, Administrative	16 M12	233,851	(233,851)
					Commission of the control of the con			
All Care Centers,				ľ	hene Commence 4011: Denotion and Incurrence alone counier	the consistent base love	ar operitons	
mgmt co, realty cos	44 14 woodstand		1	4	Share Common 401K, Pension and Insurance plans, council, legal and various other services	legai and various ou	ler services	

<sup>\*</sup> Use additional sheets if necessary.

\*\* Provide the percentage amount of revenue received from non-related parties.

### **General Information and Questionnaire Basis for Allocation of Costs**

Name of Facility	License No.		Report for Year Ended	Page	of
Universal Healthcare Holdings LLC	2541		9/30/2019	5	37
If the facility is licensed as CDH and/or RCH or	provides Al	DS or TBI	services with special Medica	id rates, co	sts
must be allocated to CCNH and RHNS as follow	vs:		•	,	
Item			Method of Allocation	n	
Dietary		Number of	meals served to residents		
Laundry		Number of	pounds processed		***
Housekeeping		Number of	square feet serviced		
		Number of	hours of routine care provide	d by EACH	I
Nursing			lassification, i.e., Director (or	_	,,
		Registered !	Nurses, Licensed Practical N	urses, Aide	s and
		Attendants			
Direct Resident Care Consultants		Number of	hours of resident care provid	ed by EAC	H
		specialist (	See listing page 13)		
Maintenance and operation of plant		Square feet			
Property costs (depreciation)		Square feet			
Employee health and welfare	~	Gross salar			
Management services			e cost center involved		
All other General Administrative expenses			rect and Allocated Costs		
The preparer of this report must answer the follo	wing question	ons applical	ole to the cost information pro	ovided.	
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why su	ich allocation	on was
costs allocated as required?	0 103	O 190	not made.		
2. Explain the allocation of related company exp	enses and at	tach copy o	of appropriate supporting data	ì.	
3. Did the Facility appropriately allocate and sel	f-disallow d	irect and inc	direct costs to non-nursing ho	me cost cer	nters?
(e.g., Assisted Living, Home Health, Outpatie	ent Services,	Adult Day	Care Services, etc.)		
	⊙ Yes	O 110	If "No," explain fully why su not made.	ch allocatio	on was
				VI	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

## General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals

37  $_{
m o}$ Amount Claimed 1,783 317 Page of Lease Amount Annual 1,783 317 Term of 60 months & Report for Year Ended Lease automatic 9/30/2019 Lease\*\* Date of 02/01/19 02/01/19 Description of Items Leased Fime Clocks and Payroll Punch Equip 2541 License No. Postage Rental Related \* to Š Operators, 0 0 0 0 0 • 0 0 0 • Officers Owners, Yes 0 0 0 0 0 O O 0 0 0 should not be included in these amounts. Name and Address of Lessor Universal Healthcare Holdings LLC P.O. Box 856390, Louisville, KY 40285-6390 ADP, Inc., One ADP Drive MS-100, Name of Facility Augusta, GA 30909 Pitney-Bowes

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also. Is a Mileage Log Book Maintained for All Leased Vehicles?

2,100

Total \*\*\*

% ©

O Yes

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

### Annual Report of Long-Term Care Facility

CSP-7 Rev. 6/95

### General Information and Questionnaire Accounting Basis

1 -		Report for Year Ended		rage	1 20
Universal Healthcare Holdings LLQ	2541	9/30/2019		7	37
The records of this facility for the per	riod covered by this report	were maintained on the following basis:			
• Accrual O Cash O N	Modified Cash				
Is the accounting basis for this					
[±	les .	If "No," explain.			
previous period? O N	lo .				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code		0.51.00	
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, Weth	ersfield, CT	06109	
2					
3					
4	21 ( 11 )	I			
Services Provided by This Firm (desc	crive jully )			······································	
1 Taxes, financial statements, accounting s	support		\$		
2			\$		
3			\$		
4		And the second of the second o	\$		
			Charge for S	Services I	Provided
			\$		
Are These Charges Reflected in the Expenditu	ure Portion of This Report? If Ye	s, Specify Expense Classification and Line No.	1		
	5D				
Legal Services Information					
Name of Legal Firm or Independent	Attorney		Telephone l	Jumber	
1 iCare Health Management, LLC			860-570-21	40	
2 Starble and Harris			860-678-77	75	
3 Durant Nichols / Robinson & Co			860-275-82	00	
		, Murtha Cullina, Jackson Lewis))			
5 Starble and Harris, iCare Health			860-678-77	75 & 860	)-570-2140
Address (No. & Street, City, State, Z	-				
1 341 Bidwell Street, Manchester	CT				
2 32 Main Street, Avon, CT					
3 280 Trumbull St, Hartford, CT					
5 22 Main Street Aven CT & 2/	41 Didwell Otace Men to	oton CT			
5 32 Main Street, Avon, CT & 34		SEEF C I			
Services Provided by This Firm (des	crive jully )				
1 Lease and contract issues, general legal			\$	13,792	
2 Lease and contract issues, general legal			\$		
3 Employment law, arbitrations, contract			\$		
4 Employment Arbitrations, healthcare la	W		\$	3,162	
5 Conservatorships & Collections			\$	1,534	
			Charge for	Services :	Provided
			\$	18,487	
Are These Charges Reflected in the Expendit	ure Portion of This Report? If Ye	es, Specify Expense Classification and Line No.			
• Yes O No	15E				

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

### Schedule of Resident Statistics

Total All CCNH RHNS Total Total CCNH RHNS Total Total Levels (Specify) Total All CCNH RHNS Total Total A. On last day of PREVIOUS report period 150 150 150 150 150 150 150 150 150 150	Total (Specify) Total 150 150 151 157		Period 10/1 Thru 6/30  CCNH RHNS (Specify)  150  150  137	Total 150 150	CCNH 150 150 137	Period 7/1 Thru 9/30  CCNH RHNS  150  150  137	(Specify)
Total All   Total   Total     Certified Bed Capacity   Certified Bed Capacity   Levels   Level   Level   Specify)   Tevels   Level   CCNH   RHNS   Total     A. On last day of PREVIOUS report period   150   150   150   150     B. On last day of THIS report period   150   150   150   150     A. As of midnight of PREVIOUS report period   142   142   142     Total Number of Days Care Provided During Period   1,465   1,465   1,465     B. Medicare   1,465   1,465   1,465     B. Medicaid (other states)   31,239   1,359     C. Medicaid (other states)   1,465   1,465     C. Medicaid (other states)   1,465     C. Medicaid (other st	Tot	CCN		Tot	CCNH 150 150	RHNS	(Specify)
Certified Bed Capacity         Levels         Levels         Level         Operation           A. On last day of PREVIOUS report period         150         150         150         150           B. On last day of THIS report period         150         150         150         150           A. As of midnight of PREVIOUS report period         142         142         142           B. As of midnight of THIS report period         1,465         1,465         1,465           A. Medicare         A. Medicare         1,465         1,465         1,465           B. Medicaid (other states)         21,239         31,239         21,239         21,239				TO TO	150		(Append)
A. On last day of PREVIOUS report period       150       150       150         B. On last day of THIS report period       150       150       150         Number of Residents       A. As of midnight of PREVIOUS report period       142       142         B. As of midnight of THIS report period       142       142         Total Number of Days Care Provided During Period       1,465       1,465         A. Medicare       31,239       31,239         B. Medicaid (other states)       31,239       146	15.1			150	150		
B. On last day of THIS report period       150       150       150         Number of Residents       A. As of midnight of PREVIOUS report period       142       142         B. As of midnight of THIS report period       145       145         Total Number of Days Care Provided During Period       1,465       1,465         A. Medicare       31,239       31,239         B. Medicaid (other states)       C. Medicaid (other states)	150			150	150		
Number of Residents A. As of midnight of PREVIOUS report period B. As of midnight of THIS report period Total Number of Days Care Provided During Period A. Medicare B. Medicare C. Medicaid (other states)  A. Medicaid (other states)	13,				137		·
A. As of midnight of PREVIOUS report period  B. As of midnight of THIS report period  Total Number of Days Care Provided During Period  A. Medicare  B. Medicard (Conn.)  C. Medicaid (other states)  A. As of midnight of THIS report period  1,465  1,465  1,465  21,239  C. Medicaid (other states)	13.			•	137		LL LIBERT WAS TO THE
<ul> <li>B. As of midnight of THIS report period</li> <li>Total Number of Days Care Provided During Period</li> <li>A. Medicare</li> <li>B. Medicaid (Conn.)</li> <li>C. Medicaid (other states)</li> <li>D. As of midnight of THIS report period</li> <li>1465</li> <li>1,465</li> <li>1,465</li></ul>	13.			137			
Total Number of Days Care Provided During Period         1,465         1,465           A. Medicare         1,465         1,465           B. Medicaid (Conn.)         31,239         31,239           C. Medicaid (other states)         1,465         1,465	×	:		142	142		
Medicare         1,465         1,465           Medicaid (Conn.)         31,239           Medicaid (other states)         31,239	3.5	_					
Medicaid (Conn.) 31,239 31,239 Medicaid (other states)		0 850		615	615		
	18,966	6 18,966		12,273	12,273		
D. Private Pay 62 62	09	09 0		2	2		
E. State SSI for RCH							
F. Other (Specify) Insurance 82 82		12 12		70	70		
G. Total Care Days During Period (3A thru F) 32,848 32,848	19,888	8 19,888		12,960	12,960		
4. Total Number of Days Not Included in Figures in 3G							
for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days							
B. Other Bed Reserve Days							
5. Total Resident Days (3G + 4A + 4B) 32,848 32,848	19,888	8 19,888		12,960	12,960		A CONTRACTOR OF THE CONTRACTOR

### **Annual Report of Long-Term Care Facility**

CSP-9 Rev. 9/2002

**Schedule of Resident Statistics (Cont'd)** 

Name of Facil	lity			Licen	ise No.			İ	Report	for Year	Ended		Page	of
Universal Hea	•	Holding	s LLC	2	2541				_	9/30/201	9		9	37
			1	***************************************										
<ol><li>Were the</li></ol>	ere any c	hanges	in the certified b	ed ca	pacity du	ring t	he repo	rt yea	r?	0	Yes	•	No	
If "YES"	, provid	e the fol	lowing informat	ion:										
		Place of	Change		Ch	ange	in Bed	8		Ca	pacity Afte	r Change		
Date of	CCNH	RHNS	(Specify)		Lost		(	Gaine	i					
ar.														
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason fo	r Change
5 If there v	vas anv	change :	in certified bed c	anaci	tv during	the r	eport v	ear (as	report	ed in iten	1 4 above)	provide the nun	nber of	
	•	_	90 days followin	-	-		·Port j		F			<b>r</b>		
KLOIDI	MIDA	1 5 101	o days followin	guic	change.									
			Changa in Da	aida.	at Davea						NH	RHNS	(Spe	cify)
1 st chan	πo		Change in Re	siuei	n Days					<u> </u>	\1\11	KITAD	(Spc	UII y
2nd char										<del>                                     </del>				
3rd chan														
4th chan														
		lents an	d Rates on Septe	ptember 30 of Cost Year										
			Medicare		Medi	caid				Self-Pay			Other Stat	e Assisted
										Boll-1 dy				
	Item		CCNH	C	CNH	R1	HNS	CC	CNH	RI	INS	(Specify)	R.C.H.	ICF-MR
No. of R		3	6		134				2					
Per Dien														
a. One b			385.00		253.00			<u> </u>	399.00	ļ				
	bed rms									<u> </u>				
c. Three		е						l						
bed 1	rms.					L		<u> </u>		ļ				
7 T-4-1 NT-		f Dleveni e	ol Thomas Tuest							T.	TAI	CONTT	DING	(Panale)
		rnysica are - Par	al Therapy Treat	meme	5						1,928	CCNH 1,928	RHNS	(Specify)
			lusive of Part B)											
]			e Treatments								336	336		
			Treatments								2,376	2,376		
C.	Other										2,403	2,403		
D.	Total 1	Physical	Therapy Treati	nents	<u> </u>						7,043	7,043		
			Therapy Treatn	ents										
		are - Par						***********			148	148		
В.			lusive of Part B)	)										
			e Treatments							<b></b>	29	29		
		torative	Treatments								99	99		
	Other	Cnaach '	The annual Tuesday	are ta							124	124		
			Therapy Treatm		*******						400	400		
		are - Par	ational Therapy '	reau	nents						2.022	2.022		
			lusive of Part B)								3,033	3,033		
J.			ce Treatments	,							253	253		
	******************		Treatments								2,224	2,224		
C.	Other									<del>                                     </del>	2,611	2,611		
		Оссира	tional Therapy T	Freati	nents						8,121	8,121		

### **Annual Report of Long-Term Care Facility**

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	· · · · · · · · · · · · · · · · · · ·	- Salain				
Name of Facility	License No.		Report for Year	Ended	Page	of
Universal Healthcare Holdings LLC	2541		9/30/2019		10	37
Are time records maintained by all individuals receiving con	nensation?	0	Yes	0	No	
Ale this records maintained by an incividuals recorving con	rponsarion:			******		
			Total Cost at	id Hours	I	
			1			
<u>Item</u>	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I						
of Schedule A1) 2. Administrator(s) (Complete also Sec. III						
l control of the cont	90,186	1,173				330000000000000000000000000000000000000
of Schedule A1)  3. Assistant Administrator (Complete also Sec. IV	90,180	1,173				
· -		<b>\$</b>	T			
of Schedule A1) 4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	141,001	6,450				
5. Dietary Service	141,001	0,750				
a. Head Dietitian	22,521	709	***************************************	000000000000000000000000000000000000000		
b. Food Service Supervisor	33,551					
c. Dietary Workers	281,954					
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	41,072 46,309					
b. Other Maintenance Workers	46,309	2,740				
Laundry Service     a. Supervisor						
b. Other Laundry Workers						
Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant					224224624474444444	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
b. Other Accountants						***************************************
12. Professional Care of Residents						
<ul> <li>a. Directors and Assistant Director of Nurses</li> </ul>	141,481	2,701				
b. RN						
1. Direct Care	247,230					
2. Administrative**	133,571	3,054	<u> </u>			
c. LPN	1,000,760	21.50				
Direct Care     Administrative**	1,000,769	31,521		-		<u> </u>
d. Aides and Attendants	1,310,993	70,271			1	
e. Physical Therapists	1,310,333	10,411	`	<del>                                     </del>		<b> </b>
f. Speech Therapists		1	1	<b>-</b>		
g. Occupational Therapists				1		
h. Recreation Workers	70,108	3,248	3			
i. Physicians						
Medical Director					1	
2. Utilization Review		1	1			<u> </u>
3. Resident Care***	1					
4. Other (Specify)			1			#
j. Dentists			ļ	1	-	<del>                                     </del>
k. Pharmacists	-				+	
l. Podiatrists	-	+	+			<u> </u>
m. Social Workers/Case Management	56,769	2,010	5			1
n. Marketing	1 30,703	2,010		† · · · · ·		
o. Other (Specify)						
See Attached Schedule	38,508		9			
A-13. Total Salary Expenditures	3,656,023	149,653	3			

<sup>\*</sup> Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

<sup>\*\*</sup> Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

<sup>\*\*\*</sup> This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

### Schedule of Other Salaries and Wages (Page 10)

		CC	NH	RE	INS	(Spe	cify)
Position		\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$					\$ -	
MEDICAL RECORDS SALARIES	\$	20,017	1,236			\$ -	•
CENTRAL SUPPLY SALARIES	\$	18,491	1,103			\$ -	
RESPIRATORY THERAPY SALARIES	\$					\$	
							districts.
	S	38,508	2,339	6		\$	
Total	3	38,308	2,339	] 0	1	Ψ	1

### Schedule of Other Fees (Page 13)

		CCI	NH	R	HNS	(Spe	cify)
Service		\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$	7,912				\$ -	
ADMISSIONS C/S LABOR	\$	36,161	939			\$	
CENTRAL SUPPLY CONTRACT SERVICE	S	6,558	186			\$ -	
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$	79,558	1,862			\$ -	
RESPIRATORY THERAPY CONTRACT SERVICES	\$	250	3			\$ -	
PHYSICAL THERAPY C/S MEDICIAD	\$	41,752	711			\$ -	
SPEECH THERAPY C/S Medicaid	\$	3,053	72			<b>\$</b> ⊢	
OCCUPATIONAL THERAPY C/S MEDICIAD	\$	34,833	657			\$ -	
	e recession		kisu jiraya birtasirk				
Total	\$ 2	210,077	4,429	\$ -		\$	

Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005 State of Connecticut

## Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

Name of Recility		7	registan	I icense No	Tisense No Report for Year Ended	Renort for	Report for Year Fuded	and the state of t	Page	Jo
Universal Healthcare Holdings LLC	Q			2541		9/30/2019			11	37
		Colon Dai	7							
		Salary Faid		Fringe Benetits		Total	Line Where		Total	
Name	CCNH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.	be consider	red unless f	ull informati	on is provided. Us	e additional sheets if n	equired.				

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets it required.

<sup>\*\*</sup> Include all employment worked during the cost year.

Annual Report of Long-Term Care Facility CSP-12 Rev. 10/2005 State of Connecticut

# Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

Universal Healthcare Holdings LLC Salary Paid Name CCNH RHNS	and the second s	25.41		orogono	-			
CCNH		25.41		0.000000				
CCNH		717		9/30/2019			12	37
CCNH	Paid							
CCNH		rnnge Benetits and/or Other			Line Where		Total	
CCNH			Full Description of	Total Hours	Claimed on	Name and Address of All	Hours	Compensation
XX and the second of the secon	S (Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Keceived
Section 111 - Administrators								
		same as						
		employees less						
George Kingston 90,186		union funds	Administrator	1,173 A2	A2			
The state of the s		same as						
		employees less						
		union funds	Administrator	-	A2			
		same as						
		employees less						
		union funds	Administrator		A2			
Soution IV Assistant				***************************************				
Administrators								
*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.	ss full inform	tion is provided. Use	additional sheets if req	uired.				

<sup>\*\*</sup> Include all other employment worked during the cost year.

<sup>\*\*\*</sup> If more than one Administrator is reported, include dates of employment for each.

CSP-13 Rev. 9/2002

**B.** Report of Expenditures - Professional Fees

Name of Facility	License No.	<del>****</del>	Report for Y		Page	of
Universal Healthcare Holdings LLC	254	ł1	9/30/2019		13	37
			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	15001	220				
3. Pharmacist	16,394	228				
4. Podiatrist						
5. Physical Therapy	40.040	722				
a. Resident Care	48,249	733				
b. Other	(2.020	1 000				
6. Social Worker	62,939	1,202				25.0.11
7. Recreation Worker	13,047	35+Cable				35+Cable
8. Physicians	20.006	<b>4</b> 0.4				
a. Medical Director (entire facility)	38,906	284				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility  I. Infection Control Committee						
(Quarterly meetings)						
2. Pharmaceutical Committee				1		
(Quarterly meetings)						
Staff Development Committee     (Once annually)					j	
e. Other (Specify)  Physician Care Contract Services	13,065	42				
9. Speech Therapist	13,003	42				
a. Resident Care	6,761	88				
b. Other	0,701	00				1
10. Occupational Therapist						
a. Resident Care	66,199	732				
b. Other	00,100	,,,,				
11. Nurses and aides and attendants						
a. RN						
Direct Care	9,483	80				
2. Administrative***	91,476	1,520				-
b. LPN						
1. Direct Care	4,747	113	***************************************	T	***************************************	***************************************
2. Administrative***	-7					
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	210,077	4,429		·		<b>4</b> ************************************
B-13 Total Fees Paid in Lieu of Salaries	581,342	9,451				

<sup>\*</sup> Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

<sup>\*\*\*</sup> This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

<sup>\*\*\*</sup> Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

### Report of Expenditures Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility	License No.		Report for	Year Ended	Page	of
Universal Healthcare Holdings LLC	2541		9/30/2019		14	37
			to Owners,			
Name & Address of Individual	Full Explanation of Service		rs, Officers	Explai	nation of R	elationship
Tocuhpoints Therapy	Therapy	Yes	No	Common Own	ershin	
Totalpoints Therapy	Тистару	•	0	Common own	oromp	
Chelsea Place, Chestnut Point, Kettle Brook,	Shared Employees	•	0	Common Own	ership	
Trinity Hill, Wintonbury, Farmington, Silver	71					
Pharm Scripts	Pharmacy Contract	0	•			
Guardian Consulting Srv	Pharmacy Consulting	0	0			
Healthdrive Physician Services	Audiology, Dental and Podiatry	0	0			
Ready Nurse, Nurse Network	Nursing pool (RN, LPN,CNA)	0	0			
Stearling Physician	Medical Director	0	0			
Dr. Ramirez Gilberto	Medical Director	0	0			
		0	0			
		0	0		•	
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	•			
		0	•			
		0	•			
		0	0			
		0	0			
		0	0			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

### C. Expenditures Other Than Salaries - Administrative and General

Name o	of Facility	License No.		Report for Yo	ear Ended	Page	of
Univer	sal Healthcare Holdings LLC	2541		9/30/2019		15	37
	_						
	Item			Total	CCNH	RHNS	(Specify)
1. Ad	ministrative and General						
a.	Employee Health & Welfare Benefits						
	1. Workmen's Compensation		\$	141,647	141,647		
	2. Disability Insurance		\$	***			
	3. Unemployment Insurance		\$				
	4. Social Security (F.I.C.A.)	· · · · · · · · · · · · · · · · · · ·	_\$	346,501	346,501		
	5. Health Insurance		\$	699,506	699,506		
	6. Life Insurance (employees only)						
	(not-owners and not-operators)		\$				
	7. Pensions (Non-Discriminatory)		\$	230,290	230,290		
	(not-owners and not-operators)						
	8. Uniform Allowance		\$				
	9. Other (Specify)		\$	28,416	28,416		
	See Attached Schedule						
b.	Personal Retirement Plans, Pensions, and		\$				
	Profit Sharing Plans for Owners and						
	Operators (Discriminatory)*						
C.	Bad Debts*		\$	(0)	(0)		
d.	Accounting and Auditing		\$		, ,		
e.	Legal (Services should be fully described	on Page 7)	\$		18,487		
f.	Insurance on Lives of Owners and		\$				
	Operators (Specify)*						
g.	Office Supplies		\$	9,893	9,893		
h.	Telephone and Cellular Phones		<b>-</b>	3,023	3,033		
	1. Telephone & Pagers		\$	7,003	7,003		
	2. Cellular Phones	****	\$	<del></del>	754		
i.	Appraisal (Specify purpose and		\$		751		
**	attach copy)*		Ψ				
	under copy )						
i	Corporation Business Taxes (franchise tax	r)	\$	250	250		
k.	Other Taxes (Not related to property - Sec		φ	2.30	230		
Κ.	1. Income*	2 1 ugc 22)	\$				
	2. Other ( <i>Specify</i> )		<u> </u>				<del>                                     </del>
	See Attached Schedule		Φ				
			ď١	600.465	(00.465		
Subtot			\$	<del></del>	690,465		
Subtol	ut		\$	2,173,212	2,173,212	<u> </u>	<u> </u>

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### \*\*\* DO NOT Include Holiday Parties / Awards / Gifts to Staff

Attachment Page 15

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	(Specify)
UNION TRAINING	\$ 28,416		\$
Total	\$ 28,416	\$ -	\$ -

### **Schedule of Other Taxes**

Description	CCNH	RHNS	(Specify)
INTERNET EXPENSES	\$ -		\$ -
Total	\$ -	\$ -	\$ -

### C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Universal Healthcare Holdings LLC	2541		9/30/2019		16	37
Item			Total	CCNH	RHNS	(Specify)
Subtotals	Brought Forwa	rd:	2,173,212	2,173,212		
Travel and Entertainment						
1. Resident Travel and Entertainment		\$				
Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$	229	229		
5. Education Expenses Related to Seminars and	Conventions	\$	1,781	1,781		
6. Automobile Expense (not purchase or depred	ciation)	\$				
7. Other (Specify)		\$	858	858		
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses	)	\$	9,219	9,219		***************************************
2. Advertising Telephone Directory (all such exp		\$				
3. Advertising Other (Specify)***		\$	10,566	10,566		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service is	supplied	\$				
directly and not by contract or fee for service)						
7. Postage		\$	3,128	3,128		
* 8. Dues and Membership Fees to Professional		\$	2,543	2,543		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	llowable Org.***	\$				
9. Subscriptions	······································	\$	· · · · · · · · · · · · · · · · · · ·			
10. Contributions***		\$				
See Attached Schedule						
11. Services Provided by Contract (Specify and C	Complete	\$	65,082	65,082		
Schedule C-2, Page 21 for each firm or indiv	•					
12. Administrative Management Services**		\$	233,851	233,851		
13. Other (Specify)		\$	13,290	13,290		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	2,513,759	2,513,759		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
MEALS	\$ 858		\$
			- KONDELYA
Total Other Travel and Entertainment	\$ 858	\$	\$

### Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 10,566		8
Total Other Advertising	\$ 10,566	\$	\$ -

### Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTOFM			
CAHCF Dues	\$ 2,383		\$
OTHER DUES	\$ 160		\$
	110404	Profited the	
			1 10 10 104 1
Total Dues	\$ 2,543	\$ -	\$

### Schedule of Contributions

RHNS (S	pecify)
- \$	
- \$ - \$	

### Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$		\$ -
SOC SVC MINOR EQUIPMENT	\$		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 3,903		s -
EMPLOYEE RELATIONS	\$ 421	Hindulfia Irau	\$ -
EMPLOYEE RELATIONS-OTHER	\$ 574		\$
PERMITS & LICENSES	\$ 2,030		\$ -
VOLUNTEER EXPENSE	\$ .		\$
BANK PEES	\$ 4,447		\$ -
CMS REVISIT USER FRES	\$ -		\$ -
PENALTIES	\$ -		\$
LATE FEES	\$ 181		\$ -
INTERNET EXPENSES	\$ 1,735		S -
Rounding	\$ (1)		
			tes services
Total Other Administrative and General	\$ 13,290	\$ -	\$ -

### Schedule C-1 - Management Services\*

Name of Facility	License No.	Report for Year Ended	Page of
Universal Healthcare Holdings LLC	2541	9/30/2019	17   37
Name & Address of Individual or Company Supplying Service iCare Management, LLC/iCare Health	Cost of Management Service 233,851	Full Description of Mgmt. Service Provided  Management of financial	Indicate Where Costs are Included in Annual Report Page #/Line # Pg 16 M12
Management, LLC		statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	
iCare Management, LLC/iCare Health Management, LLC	132,048	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	18,484	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

<sup>\*</sup> In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

				Page 5)	•				
Nan	ne of Facility		License		_		ar Ended	Page	of
Univ	versal Healthcare Holdings LLC			2541	9/30	)/2019		18	37
	Item			Total	CC	NH	RHNS	(S <sub>l</sub>	ecify)
2.	Dietary								
	a. In-House Preparation & Service								
	1. Raw Food	~~~~	\$	189,352	18	39,352			
	2. Non-Food Supplies		\$	12,687		12,687			
	3. Other (Specify)		\$	19,853		19,853			*********************
	DIETARY SUPPLEMENTS								
	b. Purchased Services (by contract other		\$	1,033		1,033			
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)								
	c. Other (Specify)		\$	4,597		4,597			
	DIETARY MINOR EQUIPMENT								
2D.	Total Dietary Expenditures $(2a + b + c + d)$		\$	227,522	22	27,522			
2E. F.	Dietary Questionnaire  Resident Meals: Total no. of meals served per d	 lay:*	*	Total	CC	NH 270	RHNS	(S	pecify)
G.	Is cost of employee meals included in 2D?	0 1	Yes	0	No				
Н.		0 1			No		If yes, specify amt.	***************************************	errormania del comunica del com
I.	Where is the revenue received reported in the C	ost l	Report	? (Page/Line I	tem)				
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	0 1	Yes	•	No		If yes, specify cost.		
K.	Is any revenue collected from these people?	0 '	Yes	•	No		If yes, specify amt.		
L.	Where is the revenue received reported in the C	ost l	Report	? (Page/Line I	tem)				
М.	Is cost of food (other than meals, e.g., snacks	0 '			No		If yes, specify cost.		
N.	Is any revenue collected from employees?	0 '	Yes	•	No		If yes, specify amt.		
O.	Where is the revenue received reported in the C	ost	Report	? (Page/Line I	tem)				

<sup>\*</sup> Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

### C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs (See Note on Page 5)

	ne of Facility		License				ear Ended	Page	of
Uni	versal Healthcare Holdings LLC			2541	9/30	/2019	<u></u>	19	37
	Item			Total	CC	NH	RHNS	(Sp	ecify)
3.	Laundry  a. In-House Processing*  1. Bed linens, cubicle curtains, draperies, gowns and other resident care items		Lbs.	104		104			
	washed, ironed, and/or processed.***		Am. p	104		104			
	Employee items including uniforms, gowns, etc. washed, ironed and/or		Lbs.						
	processed.***		Amt. \$						
	3. Personal clothing of residents		Lbs.						
	washed, ironed, and/or processed.***		Amt. \$						
	4. Repair and/or purchase of linens.***		Lbs.	•					
	1 D -1 -1 1 C - 1 - 1		Amt. \$		<u> </u>				
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	247,397	24	47,397			
3D.	c. Other (Specify)  LAUNDRY MINOR EQUIPMENT  Total Laundry Expenditures (3a + b + c)		\$			45.501			
3E.	Laundry Questionnaire		\$	247,501	24	47,501			
F.		0	Yes	•	No		If yes, specify cost.		WW.h
G.	Did you receive revenue from employees?	0	Yes	•	No		If yes, specify amt.		
H.	Where is the revenue received reported in the Co	st l	Report?		(Pag	e/Line		<del></del>	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	0	Yes	•	No		If yes, specify cost.		
J.	Did you receive revenue from these people?		Yes	•	No		If yes, specify amt.		
K.	Where is the revenue received reported in the Co	st ]	Report?		(Pag	e/Line	Item)		

<sup>\*</sup> Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3D.

<sup>\*\*\*</sup> Pounds of Laundry only required for multi-level facilities.

### C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	ì	Repo	ort for Year E	nded	Page	of
Universal Healthcare Holdings LLC	2541		9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced					
a. In-House Care	by Personnel					
1. Supplies - Cleaning (Mops,	Amt.	\$	17,221	17,221		
pails, brooms, etc.)						
b. Purchased Services (by contract other	Sq. Ft. Serviced					
than through Management Services)	by Personnel					
(Complete Schedule C-2 att.	Amt.	\$	263,107	263,107		
Page 21)						
C. Other (Specify)		\$				
HOUSEKEEPING MINOR EQUII	PMENT					
4D. Total Housekeeping Expenditures (4a +		\$	280,328	280,328		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$	89,902	89,902		
PHARMACY						
b. Medicine Cabinet Drugs		\$	10,353	10,353		
c. Medical and Therapeutic Supplies		\$	100,113	100,113		
d. Ambulance/Limousine***		\$	694	694		
e. Oxygen						
1. For Emergency Use		\$	4,321	4,321		
2. Other***		\$				
f. X-rays and Related Radiological		\$	993	993		
Procedures***						
g. Dental (Not dentists who should be inc	luded under	\$				
salaries or fees)						
h. Laboratory***		\$	2,994	2,994		
i. Recreation		\$				
j. Direct Management Services*		\$				
k. Indirect Management Services*		\$				
1. Other (Specify)****		\$		197,767		
See Attached Schedule						
5M. Total Resident Care Expenditures (5a - 5	5j)	\$	407,136	407,136		

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*</sup> Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### **Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
NURSING ADMIN SUPPLIES	\$ 28		\$ -
NURSING MINOR EQUIP	\$ 4,253		\$ -
MEDICAL RECORDS SUPPLIES	\$ 1,952		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 132,048		\$ -
NON-COVERED PPS DR. VISITS	\$ 28		\$ -
RESIDENT CARE SUPPLIES	\$ 39		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 3,503		\$ -
PERSONAL CARE SUPPLIES	\$ 581		\$ -
INCONTINENCY SUPPLIES	\$ 1,557		\$ -
VACCINE RESIDENTS	\$ 50		\$
PATIENT SPECIAL NEEDS	\$ 38		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		s -
SPEECH THERAPY SUPPLIES	s -		<b>  \$</b>
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 24,049		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ -		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ +		\$
IV THERAPY SUPPLIES	\$ 2,179		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,726		\$ -
ACTIVITIES SUPPLIES	\$ 3,351		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ 3,902		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 18,484		- \$
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
Total Other Resident Care	\$ 197,767	\$ -	<b>S</b> -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

Schedule C-2 - Individuals or Firms Providing Services by Contract \* Report of Expenditures

Name of Facility Universal Healthcare Holdings LLC	s TTC			License No. 2541	Report for Year Ended 9/30/2019				Page 21	of 37
		Related ** to Owners, Onerators Officers	to Owners,			_	Total Cost/	Total Cost/Page Ref.***		
		- Lower do	2					0		
Name of Individual or Company	Address	Yes	Ñ	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg L	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Housekeeping Services	263,107			20 46	<b>(</b> )
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	247,397			19 3	36
Eagle Elevator		0	•	VENDOR	Elevator Contract				22 6	6F
Bioserve, Inc.		0	0	VENDOR	Medical Waste	1,726			22 6	6F
MLG Landscaping LL/Scenic Landscapes LLC		0	0	VENDOR	Snow Removal/Landscaping	17,681			22 6	6F
All West Inc		0	0	VENDOR	Trash removal	12,002			22 6	6F
American HealthTech		0	0	VENDOR	Software Maintenance Contract	9,507			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	22,826			16 1	M11
National Datacare Corp		0	0	VENDOR	Resident Trust Software	2,285			16 1	M11
Prime Care Technologuy services	- Line and the second s	0	•	VENDOR	Computer Consulting Services	19,779			16 h	MII
Priotiry Express	Audobabookmovementerererere	0	0	VENDOR	Courier Services	2,321			16 1	Mil
Point Right Inc		0	0	VENDOR	Nursing Software		Manuelle		16 1	MII
- Action and Action an		0	0	VENDOR					22 6	6F
	a philing and a second	0	•	VENDOR						The second second

 $<sup>\</sup>ast$  List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

### C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility License No	),	Report for Ye	ear Ended		Page	of
Universal Healthcare Holdings LLC 2541		9/30/2019			22	37
Item		Total	CCNH	RHNS	(Spe	ecify)
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	33,555	33,555			
b. Heat	\$	12,710	12,710			
c. Light & Power	\$	138,870	138,870			
d. Water	\$	38,356	38,356			
e. Equipment Lease (Provide detail on page 6)	\$	2,100	2,100			
f. Other (itemize)	\$	71,550	71,550			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	297,141	297,141			
7. Depreciation (complete schedule page 23*)			. "			
a. Land Improvements	\$				l	
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	11,200	11,200			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	11,200	11,200			
8. Amortization (Complete att. Schedule Page 24*)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	143	143			
d. Other (Specify)	\$					
*8e. Total Amortization Costs $(8a+b+c+d)$	\$	143	143			
9. Rental payments on leased real property less						
real estate taxes included in item 10b	\$	194,672	194,672			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	193,646	193,646			
c. Personal property taxes	\$	38	38			
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)	\$	399,701	399,701			

<sup>\*</sup> Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

### Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS (Specify)
PLANT SUPPLIES	\$ 12,933	<b>3 3 3 3 3 3 3 3 3 3</b>
PLANT CONTRACT SERVICE LABOR	\$ -	**************************************
ELEVATOR CONTRACT SERVICE	\$ -	\$
FIRE/SPRINKLER CONTRACT SERVICE	\$ 7,830	\$ -
LANDSCAPING CONTRACT SERVICE	\$ 9,503	\$
SNOW REMOVAL CONTRACT SERVICE	\$ 8,178	\$
TRASH REMOVAL CONTRACT SERVICE	\$ 12,002	\$
HVAC CONTRACT SERVICE	\$ -	\$
SECURITY CONTRACT SERVICE	\$ -	
PLANT CONTRACT SERVICE OTHER	\$ 12,256	<b>S</b>
PLANT MINOR EQUIPMENT	\$ 8,029	\$
RENT AUTO	\$ -	\$ -
RENT EQUIPMENT	\$ 819	########## <b>\$</b> ##########################
RENT OTHER	<b>S</b> -	\$ -
Total Other Repairs and Maintenance	\$ 71,550	\$ - \$

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006

				Deprec	Depreciation Schedule	hedule	MANAGEMENT TOTAL T	1			and the second s
Name of Facility Universal Healthcare Holdings LLC				License No. 2541	1		Report for Year Ended 9/30/2019	nded		Page 23	of 37
				Historical Cost	Less		Accumulated Depreciation to	Method of			
Property Item				Exclusive of Land	Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. Land Improvements											
1. Acquired prior to this report period											
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	schedule)										
A-4. Subtotal											
B. Building and Building Improvements											
1. Acquired prior to this report period											
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	schedule)										
B-4. Subtotal											
C. Non-Movable Equipment											
1. Acquired prior to this report period											
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	schedule)										
C-4. Subtotal											
	Is a mileage logbook maintained?		Date of Acquisition	Historical Cost	Less		Accumulated Depreciation to	Method of			
<u> </u>	No.	2	, te	Exclusive of	Salvage	Cost to Be	Beginning of Year's Operations	Computing	Useful	Depreciation for This Year	Totals
D Movable Fourinment	1000	-				ī	7	į			
and year of each vehicle)											
a, Vali Nepali. Hillsine muolinelike Colo			-				i i i i i i i i i i i i i i i i i i i				
C,											
d,											
2. Movable Equipment										· ·	
a. Acquired prior to this report period										9	
b. Disposals (attach schedule)											
c. Acquired during this report period										00011	
(attach schedule)				117,326						11,200	000
D-3. Subtotal											11,200
E. Total Depreciation											11,200

Useful

### Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for	Land Improvements	S -		\$
Deletions:				
Total deletions for	Land Improvements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
The Track Colors				
Cotal additions for	Building Improvements	S -		\$ -
Deletions:				
		instructions		
Total deletions for	Building Improvements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
		u sa sa sa sa sa sa		
		era (menda)		
Total additions for	Non-Movable Equipment	S -		\$ -
Deletions:				
Total deletions for	Non-Movable Equipment	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

### Schedule of Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:		ROSE TO THE TOTAL CONTROL OF THE TOTAL CONTROL OT THE TOTAL CONTROL OF THE TOTAL CONTROL OF THE TOTAL CONTROL OT THE TOTAL CONTROL OF THE TOTAL CONTROL OT T		** ** ** ***
1/25/2019	Purchase Property: Reid & Riege	\$ 50,000	60	\$ 6,667
2/26/2019	Floor Lift: Direct Supply	\$ 7,324	120	\$ 427
2/27/2019	Bed & Mattress: Medline	\$ 2,630	60	\$ 307
3/1/2019	Floor Lift: Direct Supply	\$ 2,749	120	\$ 137
3/8/2019	Bed & Mattress: Medline	\$ 6,247	60	\$ 625
3/11/2019	Digital Lift Scale: Direct Supply	\$ 4,854	120	\$ 243
2/1/2019	Rebuilt Unimac Washer: Daniels Equ	\$ 7,328	120	\$ 427
7/16/2019	Mattress: Direct Supply	\$ 2,354	60	\$ 78
9/19/2019	Furniture: WB Mason	\$ 7,591	120	
9/25/2019	Bed: Medline	\$ 11,460	60	
3/31/2019	Laptop: Prime Care	\$ 2,510	60	<b>\$</b> 251
2/28/2019	Computer: Prime Care	\$ 4,495	60	\$ 524
2/28/2019	Computer: Prime Care	7,783.69	36	1,513.5
				No Lilian
Total additions for	r Movable Equipment	\$ 117,326		\$ 11,200
Deletions:				
			Parametrica	
			North Control	
Total deletions for	Movable Equipment	\$ -		\$

<sup>\*</sup>Ties to Page 23, Line D2c

### Schedule of Leasehold Improvements Acquired during this report period

Description of Item	Cost	Useful Life	Depreciation
Electrical Upgrade: Precision Electrical	\$ 2,622	180	\$ 58
Refrigerator Doors: HPC Food	\$ 4,892	120	\$ 41
Upgrade AC & Hoter Water: Saucier Mechanical SRv	\$ 2,660	120	\$ 44
		fire eveniment.	
Leasehold Improvement	\$ 10,174		\$ 143
		,	
			telete ig kaj i de Ka
Leasehold Improvement	\$ -		\$ -
	Refrigerator Doors: HPC Food  Upgrade AC & Hoter Water; Saucier Mechanical SRv  Leasehold Improvement	Electrical Upgrade: Precision Electrical \$ 2,622 Refrigerator Doors: HPC Food \$ 4,892 Upgrade AC & Hoter Water: Saucier Mechanical SRv \$ 2,660  Leasehold Improvement \$ 10,174	Electrical Upgrade: Precision Electrical \$ 2,622 180 Refrigerator Doors: HPC Food \$ 4,892 120 Upgrade AC & Hoter Water: Saucier Mechanical SRv \$ 2,660 120  Leasehold Improvement \$ 10,174

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*\*</sup>Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

### Amortization Schedule\*

Name of Facility		License No.		Report for Year Ended	r Ended		Page	Jo
Universal Healthcare Holdings LLC		2541	11	9/30/2019			24	37
				Accumulated				
	Date of			Amort. to				
	Acquisition			Beginning of	Basis for			
		Length of	Cost to Be	Year's	Computing	Rate /	Rate Amortization	
Item	Month  Year	Amortization	Amortized	Operations	Amortization**	£ %	for This Year	Totals
A. Organization Expense								
1								
2.								
3.								
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period								
(attach schedule)			10,174				143	
C-4. Subtotal								143
D. Total Amortization								143

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

## **Annual Report of Long-Term Care Facility**

CSP-25 Rev. 9/2002

## C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire

·	License No.	Report for Year En	ded		Page	of
Universal Healthcare Holdings LLC	2541	9/30/2019			25	37
11. Property Questionnaire						
Part A						
Is the property either owned by the	e Facility		_		If "Yes," comple	te Part B
or leased from a Related Party?*	- 1,	O Yes	<b>O</b> N	IA .	If "No," complete	
*If any owner or operator of this faci	lity is related by family	marriage ownershin ability	to control or		a , tolliple.	0 1 411 0.
business association to any person or						
related party transaction.						
Description	****	Total				
Date Land Purchased						
Date Structure Completed						
3. If <b>NOT</b> Original Owner, Date	of Purchase	01/11/19				
4. Date of Initial Licensure		01/11/19	]			
5. Total Licensed Bed Capacity		150				
6. Square Footage		54,138				
7. Acquisition Cost						
a. Land						
b. Building	, •					
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage 3	rd Mortgage	4th Mortg	age
1. Financing	read aroundated					
<ul><li>a. Type of Financing (e.g., fi</li><li>b. Date Mortgage Obtained</li></ul>	xed, variable)					
c. Interest Rate for the Cost	Vent					
d. Term of Mortgage (number						
e. Amount of Principal Borro						
f. Principal balance outstand						
Complete if Mortgage was I						
During Current Cost Ye						
g. Type of Financing (e.g., fr						
h. Date of Refinancing						
i. New Interest Rate						
j. Term of Mortgage (number	er of years)					
k. Amount of Principal Borro						
Principal Outstanding on 1	Note Paid-Off					
Part C - Arms-Length Leas	es for Real Proper	ty Improvements Only	У			
Name and Address of Lesso	r I	Property Leased	Date of Lease T	erm of Lease	Annual Amoun	t of Lease
				_		

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

# C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility License No.		Report for Yea	nr Ended		Page	of
Universal Healthcare Holdings LLC 2541		9/30/2019			26	37
Item		Total	CCNH	RHNS	(S	pecify)
12. Interest A. Building, Land Improvement & Non-Movable	:					
Equipment  1. First Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
Third Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
Original Loan Amount	\$					
Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$					

(Carry Subtotals forward to next page)

# C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility License N Universal Healthcare Holdings LLQ 25		Report for Y 9/30/2019	ear Ended		Page of 27   37	
Item			Total	CCNH	RHNS	(Specify)
	otals Bro	ught Forward:	10141	001111	Kanab	(Specify)
12. C. Movable Equipment	ouis Dio	ugili I oi wuru.				
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
73. 10.11	Ruic	2 mount				
Lender						
Address of Lender	Address of Lender					
2. Other (Specify)						
A. Item						
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Intere Expense (C1 + 2)	st	\$				
12. D. Other Interest Expense (Specify)		\$	8,780	8,780		
INTEREST						
13. Total All Interest Expense (12B7 + 120	C3 + 12D	) \$	8,780	8,780		
14. Insurance	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·			
a. Insurance on Property (buildings on	ly)	\$	6,109	6,109		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as sp	ecified at	ove)				
1. Umbrella (Blanket Coverage)	42,970	42,970				
<ol><li>Fire and Extended Coverage</li></ol>						
3. Other (Specify)	1,551	1,551				
Other insurance, crime						
14d. Total Insurance Expenditures (14a + b	(c) + c	\$	50,629	50,629		
15. Total All Expenditures (A-13 thru C-14		\$		8,669,862		

# D. Adjustments to Statement of Expenditures

	e of Fa	-	care Holdings LLC	Li	cense No. 2541	Report for Yea	ar Ended	Page 28	of   37
Omv	21301 1	leanin	Care Holdings LLC	<u> </u>	Total	9/30/2019		20	31
Ttom	Page	Timo			Amount of				
	Page No.		Itam Description			CCNH	DIDIC	(Smc	Life.\
			Item Description		Decrease	CUIH	RHNS	(Spe	сну)
	10 - 3	Satario	es and Wages	/h					
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$	<del>• • • • • • • • • • • • • • • • • • • </del>				
3.			Occupational Therapy	\$					·····
4.			Other - See attached Schedule	\$					
	13 - I	rofes	sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					***************************************
7.			Other - See attached Schedule	\$					
	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$		(0)			
10.			Accounting	\$					
10a.			Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	***************************************
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$		:00000000000000000000000000000000000000		**************	100000000000000000000000000000000000000
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal use)	\$					
18.			Unallowable Advertising *	\$		10,566			
19.			Income Tax / Corporate Business Tax	\$	·	10,500			
20.		<u> </u>	Fund Raising / Contributions	\$	1.				
21.		<b></b>	Unallowable Management Fees	<del></del> \$					
22.			Barber and Beauty	<u> </u>	-				
23.			Other - See attached Schedule	<del></del> \$	· · · · · · · · · · · · · · · · · · ·	30,700			
	18 - 1	Dietar	y Expenditures	φ	30,700	30,700			
24.	10-1	) iciui	Meals to employees, guests and others						
<b>Δ</b>			who are not residents	ø					
Dana	10	[ are ==	ry Expenditures	\$					
25.	17 ~ 1	Juuna							
43.			Laundry services to employees, guests	ሑ					
n.	20	<u> </u>	and others who are not residents	\$				300000000000000000000000000000000000000	300000000000
	<u> 20 - 1</u>	10use	keeping Expenditures					<b></b>	
26.			Housekeeping services to employees, guests						
			and others who are not residents	\$	1				
			Subtotal (Items 1 - 26)	\$	41,266	41,266			

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

## Schedule of Other Salaries Adjustment

			N. S
Total Other Salaries Adjustment	\$ -	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	(Specify)
Total Other	Fees Adjustments	\$ -	\$ -	\$ -

## Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16a		PENALTIES	\$ -		\$ .
16a		LATE FEES	\$ 181		\$ .
16a		PRIOR PERIOD EXPENSES			
		rounding	\$ (1)		
		Provider User Fee for Medicare days	\$ 30,520		\$ -
Total Othe	r <b>A&amp;G</b> Ad	justments	\$ 30,700	\$ -	\$

D. Adjustments to Statement of Expenditures (cont'd)

None	ame of Facility  License No.   Report for Year Ended   Page   Of									
		•	care Holdings LLC	THE	2541	9/30/2019	ear Ended	29	37	
Unive	ersai r	leannc	are Holdings LLC		Total	3/30/2019		29	31	
T4	D	τ :								
	Page		Hans Danishatian		Amount of	COM	DIDIC	(0	:c.\	
No.	No.	No.	Item Description	<u></u>	Decrease	CCNH	RHNS	(2)	pecify)	
D	20 1	>! 2 -	Subtotals Brought Forward	\$	41,266	41,266				
	20 - F		nt Care Supplies***	•						
27.			Prescription Drugs	\$						
28.			Ambulance/Limousine	\$	694	694				
29.			X-rays, etc	\$	993	993				
30.			Laboratory	\$	2,994	2,994				
31.			Medical Supplies	\$						
32.			Oxygen (non emergency)	\$						
33.			Occupational Therapy	\$						
34.			Other - See Attached Schedule	\$	28	28				
	22 - A	<b>Lainte</b>	enance and Property							
<i>35</i> .			Excess Movable Equipment Depreciation							
			See Attached Schedule	\$						
36.			Depreciation on Unallowable							
			Motor Vehicles	\$						
37.			Unallowable Property and Real							
			Estate Taxes	\$						
38.			Rental of Building Space or Rooms	\$						
39.			Other - See Attached Schedule	\$						
Page	27-1	nsura	nce							
40.			Mortgage Insurance	\$						
41.			Property Insurance	\$						
Othe	r - Mis	scella	neous							
42.			Other - Indirect	\$						
43.			Interest Income on Account Rec.	\$						
44.			Other - Miscellaneous Administrative	\$						
45.			Management Fees Direct	\$						
46.			Management Fees Indirect	\$						
47.			Other - Direct	\$						
Not .	For Pr	ofit P	roviders Only							
48.			Building/Non Movable Eq. Depreciation						••••	
			Unallowable Building Interest -							
			See Attached Schedule	\$				**************************************		
40	Total	Amo	unt of Decrease (Items 1 - 48)	<del>-</del> \$	45,974	45,974		<u> </u>		

<sup>\*\*\*</sup> Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J		27.70		
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)			
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)			i katiya mili
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)			
			eat became a m		
Total Othe	er Ancillary	y Costs	\$ 28	\$ -	\$ -

### Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Exce	ss Movabl	e Equipment Depreciation	\$	\$	\$

### Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
	Allenika.				
<b>Total Othe</b>	r Property	y Adjustments	\$ -	\$ -	\$ -

### Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ -		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ -		
22	6B	Heat (for outpatient Therapy see schedule)	\$ -		
22	6C	Light and Power (for outpatient therapy see schedule)	\$ -		
22		water (for outpatient therapy see schedule)	\$ -		
22		Repair&Maint (for outpatient therapy see schedule)	\$ -		

			age 2
Total Other Adjustr	nents	\$ - \$	\$ -

### Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Purit at Entitle					
	TY LANGUE				
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

### Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
	Alexanii Frindi Ulius a s				
Total Unal	lowable Bu	ulding Interest	\$	\$	\$ -

# Annual Report of Long-Term Care Facility

CSP-30 Rev.10/2005

## F. Statement of Revenue

F. Statement of Rev			T2 4 1		ъ	C
Name of Facility License No. Universal Healthcare Holdings LLC 2541		Report for Y 9/30/2019	ear Ended		Page 30	of 37
Offiversal Fleathcare Floridings Like 2341		7/30/2017			30	31
Item		Total	CCNH	RHNS	(Spe	cifu)
L Resident Room, Board & Routine Care Revenue		10tai	CCNII	KIIIVO	(Spc	City)
	ď	0.017.401	0.017.401			
1. a. Medicaid Residents (CT only)	\$	8,217,421	8,217,421			
b. Medicaid Room and Board Contractual Allowance **  2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$ \$		•			
3. a. Medicare Residents (all inclusive)	\$	740 501	740 501			
b. Medicare Room and Board Contractual Allowance **	\$	749,591	749,591			
4. a. Private-Pay Residents and Other	\$	55,160	55 160			·····
b. Private-Pay Room and Board Contractual Allowance **	\$	33,100	55,160			
II. Other Resident Revenue	Φ.					
	at a	(( 575	// F7F			
a. Prescription Drugs - Medicare     b. Prescription Drugs - Medicare Contractual Allowance **	<u>\$</u> \$	66,575	66,575			
c. Prescription Drugs - Non-Medicare	<u> </u>	(66,575)	(66,575)			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	44,300 (44,300)	44,300			***************************************
2. a. Medical Supplies - Medicare	<u> </u>	(44,300)	(44,300) 415			
b. Medical Supplies - Medicare Contractual Allowance **	\$	(415)	(415)		<u></u>	
c. Medical Supplies - Non-Medicare	\$	737	737			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	(737)	(737)			
3. a. Physical Therapy - Medicare	\$	116,864	116,864			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(71,448)	(71,448)			<del></del>
c. Physical Therapy - Non-Medicare	\$	96,536	96,536			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(96,536)	(96,536)		-	
4. a. Speech Therapy - Medicare	\$	16,862	16,862			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(9,052)	(9,052)			
c. Speech Therapy - Non-Medicare	\$	11,251	11,251			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(11,251)	(11,251)			
5. a. Occupational Therapy - Medicare	\$	164,348	164,348			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(88,532)	(88,532)			
c. Occupational Therapy - Non-Medicare	\$	93,658	93,658			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(92,791)	(92,791)			
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$	42,177	42,177			
III. Total Resident Revenue (Section I. thru Section II.)	\$	9,194,258	9,194,258			
IV. Other Revenue*						
Meals sold to guests, employees & others	\$		p		***************	000000000000000000000000000000000000000
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify )	\$	10,320	10,320			
V. Total Other Revenue (1 thru 8)	\$	10,320	10,320			
VI. Total All Revenue (III+V)	\$	9,204,578	9,204,578			
L		7,204,318	7,404,3/8		<u>L.,.</u> ,	

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
14.6,52.0	Lab Medicare	\$ 10,378	[64.1 - 154]	A
	Lab Medicare CA	\$ (10,378)	4144 H	(Alberta
4,111	Oxygen Medicure	\$	5 - THE R. T. L.	
	Oxygen Medicare CA	\$		Mary Patrick
	Equipment rental	\$ 2,145	ARCHINE	(CH4 C)
	Equipment rental CA	\$ (2,145)	7 E. S.	4, ja 1,74 s
3 D. W	Pen Therapy	\$		Williams
91,731	Pen Therapy CA	\$	4 W. J. W. W.	N. P. Warry
"V"SALÇA	Therapy Beds Medicare	s -		alwari (i
	Therapy Bede Medicare CA	\$	24.14.15.4.3	ertiente:
	Radiology Medicare	\$ 684	4.15.11	
	Radiology Medicare CA	\$ (684)	india tief la	
1.300	IV Therapy	\$ 6,532	11.79 - 171 - 18	
1,1	IV Therapy CA	\$ (6,532)	to National	3 (4)
	Medical Transportation	\$		
107.0	Medical Transportation CA	S		1.5
, 10a, 150	Glucose testing	\$	68 C ( 1 C )	1 1 10 10 10 10
	Glucose testing CA	\$		15. Appen
	Outpattent therapy Medicare	S	11.14	7111
		23 27 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
eren in		190 m. m		57: 35
otal Oth	er Resident Revenue - Medicare	5	\$	2 - 2

#### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	2,070.10	F7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	100
1.00	Lab CA	(2,070.10)	111 1	. 15711.
3.504	Oxygen	S 108	ar edgilin	\$ -
	Oxygen CA	\$ (108)	11.11.11.11	\$
100	Equipment rental	\$ 9,820		73 s.e.
200	Equipment restal CA	S (9,820)	114, 154, 17	77, 77, 77
2012	Pen Therapy	\$ -	a Politica (plan	11.11.154
	Pen Therapy CA	\$	. With this	
	Therupy Beds	5	N. 18 18 18 18 18 18 18 18 18 18 18 18 18	
3 (18)	Therapy Beds CA	\$		. ( 17.50 .
	Radiology	\$ 392	18 FB4 1 3.1 m	delider.
7. je 1. m	Radiology CA	\$ (392)		
11.75	Medical Transportation	S .		
Aver po	Medical Transportation CA	\$ -	Y. 11. A. 11.	
	Glacose Testing	\$	3918),/1164	
11396	Glucose Testing CA	\$		ar sifes in
	IV therapy	\$ 2,964		3 -
- "5177	IV therapy CA	\$ (2,964)		\$
0.096	Flu shot revenue	\$		14. 101.
448 MA	Outpatient therapy	\$	unitest (d	150000
	Outpatient therapy CA	\$		
	prior period revenue	\$	- VII (%. † 1.	
1865	Ophan B	\$ 107,898		A., -44, 11.
	Oplum B CA	\$ (58,748)	177,177,1941	13 e 1. eu
1 15,500	C/A VBP	\$ (6,973)		
e in a				(112.74
*****	rounding.	\$	a manipus	
1779		A pign las	486.738	22 (SEC. 13)
otal Oth	er Resident Revenue	\$ 42,177		\$ -

## Interest Income

#### Account

Page Ref Account	Balance	CCNH	RHNS	(Specify)
INTEREST INCOME		\$	No Assisting	A SAME
	Property		100 100 100	6, 10,170.
	44.303	F - (**) - 4 (*)	100000000000000000000000000000000000000	F154511111
	20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	erijas (erakti)		in in a record
Total Interest Income		\$	s -	\$

#### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
1 1773	MEALS:	\$	Fig. Harriy 1	
275 (45)	TELEVISION INCOME	S	V 11 V 11 V	11.040
1.14	CONCESSIONS / VENDING INCOME	\$ -	A. 121/11/19	APENY U.S.
	RESIDENT LATE FEE REVENUE	\$	et 1000 (1000 )	
	RESIDENT ATTORNEY FEE REVENUE	\$	Carrier Comme	unitality (%)
risión;	TELEPHONE INCOME	\$	C.EM. 445	
	OTHER INCOME	s 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10.000
44.79	OPTUM DIVIDENDS REVENUE	\$ 10,320	50.750, 1970	
	OPTUM OUTLIERS	\$ 100	T. A. J. 1927 1. 3	Property.
Distribute	OTHER INCOME: DEFERRED REVENUE	s -	W. SHPP.	200, 0000
11.54	ALL DMHAS REVENUE	\$		1,000,000,000
7.47				
Total Oth	er Revenue	\$ 10,320	\$	

# G. Balance Sheet

Nam	e of	Facility	License No.	Report for Year Ended	P	age of
Univ	ersa	l Healthcare Holdings LLC	2541	9/30/2019	3	31   37
			Account			Amount
Asse	ts		***************************************			
A.	Cu	rrent Assets				
	1.	Cash (on hand and in banks	)		\$	2,900
	2.	Resident Accounts Receivab	le (Less Allowance	for Bad Debts)	\$	1,265,357
	3.	Other Accounts Receivable	Excluding Owners	or Related Parties)	\$	
	4	Inventories		-	\$	
	5.	Prepaid Expenses			\$	156,833
		a. Prepaid Insurance		84,094		,
		b. Prepaid Property Taxes		71,179	7	
		c. Prepaid Expenses Other		1,560		
		d. See Schedule				
	6.	Interest Receivable			\$	
	7.	Medicare Final Settlement R	eceivable		\$	
	8.	Other Current Assets (itemiz	e)		\$	(30,520)
		Due From (to) Related Parties		(30,520)		```
		Other Owners reserves			_	
		See Schedule			$\dashv$	
<b>A-</b> 9.	To	tal Current Assets (Lines A1	thru 8)		\$	1,394,570
B.	Fix	ed Assets	······································	WHI I was a second of the seco	<u> </u>	2
	1.	Land			\$	
	2.	Land Improvements	*Historical Cost		\$	
		•	Accum, Deprecia	tion Net	l'	
	3.	Buildings	*Historical Cost		\$	
		<b>-</b>	Accum, Deprecia	tion Net	ľ	
	4.	Leasehold Improvements	*Historical Cost	10,174	\$	10,030
		•	Accum. Deprecia		l'	,
	5.	Non-Movable Equipment	*Historical Cost		\$	
		• •	Accum. Deprecia	tion Net	ľ	
	6.	Movable Equipment	*Historical Cost	117,326	\$	106,125
		• •	Accum. Deprecia		ľ	,
	7.	Motor Vehicles	*Historical Cost		\$	
			Accum. Deprecia	tion Net	ľ	
	8.	Minor Equipment-Not Depre			\$	
	9.	Other Fixed Assets (itemize)			\$	10,916
		Construction in Progress		10,916		•
		See Schedule		-		
B-10.		Total Fixed Assets (Lines B	1 thru 9)		\$	127,071

<sup>\*</sup> Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

age Ref			
	Line Rei	Description	F 100 11 11 11 11 11 11 11 11 11 11 11 11
13.10	18.51.7.1		S PAGE ASSE
1,4,4,	V1.1 (1.1)		
3.5	- 11 (14, 14)		
4			
tal Treas	ald Expense		\$ +
rai r.ieh	ana expensi		LZ
hedule o	f Other Cur	rent Assets (itemized) Page 31 Line A8	
ge Ref	Line Ref	Description	T - 235, 235
11.1.1	7		31.07450
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112,1			714
			1000000
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tai Otije	Curency	asets (ttemure)	
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ge Ref		ed Assets (Itemize) Page 31 Line B9  Description	
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			1 1, 171
17 ( ) ( )	10.00		10.00
1 10 10	11.71.74		1.
- 11	17.5		1000
tal Othe	r Other Fix	ed Assets (Itemize)	S
nedule a ge Ref		ets Page 32 Line D7 Description	
4.1 14.1	11,0,0		
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stal Othe	r Assels		\$
tal Oths	of Notes Pa		
tal Oths	of Notes Pa	rable (Remize) Page 33 Line A2	3
tal Othe	of Notes Pa	rable (Remize) Page 33 Line A2	\$
tal Othe hedule o ge Ref	of Notes Pa	rable (Remize) Page 33 Line A2  Description	\$
tal Othe	of Notes Pa	rable (Remize) Page 33 Line A2  Description	\$
tal Othe hedule o ge Ref	of Notes Pa	pable (Remize) Page 33 Line A2 Description	\$
tal Othe	r Assets of Notes Pay	rable (Remize) Page 33 Line A2  Description	\$
tal Othe hedule o ge Ref	of Notes Pay	pable (Remize) Page 33 Line A2 Description	\$
tal Oths	of Notes Pay	vable (Remize) Page 33 Line A2 Description	
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# G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Pa	age	of		
Universal Healthcare Holdings LLC	2541	9/30/2019	3	2	37		
	Account			Amount			
		Total Brought Forward:	\$	1,5	521,641		
C. Leasehold or like property record	Leasehold or like property recorded for Equity Purposes.						
1. Land	- ' -		\$				
2. Land Improvements	*Historical Cost						
	Accum. Depreciation	Net	\$				
3. Buildings	*Historical Cost						
	Accum. Depreciation	Net	\$				
4. Non-Movable Equipment	*Historical Cost						
	Accum. Depreciation	Net	\$				
<ol><li>Movable Equipment</li></ol>	*Historical Cost						
	Accum. Depreciation	Net	\$				
6. Motor Vehicles	*Historical Cost						
	Accum. Depreciation	Net	\$				
7. Minor Equipment-Not Depre			\$				
C-8 Total Leasehold or Like Propert	ies (C1 thru 7)		\$				
D. Investment and Other Assets							
Deferred Deposits			\$				
2. Escrow Deposits			\$				
3. Organization Expense	*Historical Cost						
	Accum. Depreciation	Net	\$				
4. Goodwill (Purchased Only)			\$				
<ol><li>Investments Related to Residence</li></ol>	ent Care (itemize)		\$		55,077		
Patient Trust Funds		41,772					
Long Term Deposit - prim		13,305					
6. Loans to Owners or Related I	Parties (itemize)		\$				
Name and Address	Amount	Loan Date					
	1						
7. Other Assets (itemize)			\$				
See Schedule							
D-8. Total Investments and Other As			\$		55,077		
D-9. Total All Assets (Lines A9 + B1)	0 + C8 + D8		\$	1,5	576,718		

<sup>\*</sup> Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

# G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year	r Ended	Page	of	
Universal He	ealthc	are Holdings LLC	2541	9/30/2019		33	37
			Account			Am	ount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		264,500
	2.	Notes Payable (itemize)			\$	*****************************	134,681
		Working Capital Line of Cr	edit	134,6	81		
		See Schedule					
	2			\ /·· · \			
	3,	Loans Payable for Equipme		<del></del>	\$		
		Name of Lender	Purpose	Amount	Date Due		
	4.	Accrued Payroll (Exclusive	of Owners and/or S	Stockholders only)	\$		355,059
	5.	Accrued Payroll (Owners an	nd/or Stockholders	only)	\$		
	6.	Accrued Payroll Taxes Paya	ible		\$	V V V	
	7.	Medicare Final Settlement F	Payable		\$		
8. Medicare Current Financing Payable						W	,
	9.	Mortgage Payable (Current	Portion)		\$		
10. Interest Payable (Exclusive of Owner and/or Related Parties)							
11. Accrued Income Taxes*						·····	
12. Other Current Liabilities (itemize)  Related Party Payables 81,631					\$	·	195,991
Accrued Expenses 39,210							
		Accrued Resident User Fees	(1,	,913)			
		Accrued Workers Comp Expense		,063 See Schedule			
A-13	. To	tal Current Liabilities (Line	s A1 thru 12)		\$		950,231

<sup>\*</sup> Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

# G. Balance Sheet (cont'd)

Name of Facility	License No.	No. Report for Year Ended		Page	of
Universal Healthcare Holdings LLC	2541	9/30/2019		34	37
		Amo	ount		
	nt Forward:		950,231		
Liabilities (cont'd)					
B. Long-Term Liabilities					
Loans Payable-Equipment	\$	000000000000000000000000000000000000000			
Name of Lender	Purpose	Amount	Date Due		
	***************************************				
	400				
	Marin de la companya				
2. Mortgages Payable			\$		
3. Loans from Owners or Rela	ated Parties (itemize)		\$	Volid Control	
Name and Address of Lender	Amount	Loan D			
4. Other Long-Term Liabilitie	\$		41,772		
Patient Trust Funds					
See Schedule					
B-5. Total Long-Term Liabilities (	\$		41,772		
C. Total All Liabilities (Lines A-13 + B-5)					992,003

# G. Balance Sheet (cont'd) Reserves and Net Worth

	ne of Facility	License No.	Report for Yo	ear Ended	Page	of
Uni	versal Healthcare Holdings LLC	2541	9/30/2019		35	37
_		Account				Amount
A.	Reserves					
	1. Reserve for value of leased l	and	***************************************		\$	.,,,,,,,,,
	2. Reserve for depreciation val-	ue of leased buildi	ngs and appurtena	nces		
	to be amortized				\$	
	3. Reserve for depreciation val	ue of leased person	nal property ( <i>Equ</i> i	ity)	\$	
	4. Reserve for leasehold real pr	operties on which	fair rental value i	s based	\$	4,114
	5. Reserve for funds set aside a	as donor restricted			\$	
	6. Total Reserves	***	W		\$	
В.	Net Worth					
	1. Owner's Capital				\$	****
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock			Acceptable to the second secon	\$	
	5. Cumulated Earnings				\$	50,000
	6. Gain or Loss for Period	10/1/20	018 thru	9/30/2019	\$	534,716
	7. Total Net Worth				\$	584,716
C.	Total Reserves and Net Worth		·		\$	584,716
D.	Total Liabilities, Reserves, and	Net Worth			\$	1,576,718

# H. Changes in Total Net Worth

Name of Facility		License No. Report for Year E		Ended	Page	of	
Universal Healthcare Holdings LLC		2541 9/30/2019			36	37	
		Account			Amount		
A.	Balance at End of Prior Period as sl	9					
В.	Total Revenue (From Statement of			9		9,204,578	
C.	Total Expenditures (From Statemer	nt of Expenditures Pag	ge 27)	9		8,669,862	
D.	Net Income or Deficit	······································		S		534,716	
E.	Balance			9	)	534,716	
G.E.,	1. Additional Capital Contributed (itemize)						
2. Other (itemize)							
F-3.	Total Additions				)		
G.	Deductions						
	1. Drawings of Owners/Operators.		I		3		
	Name and Address (No., City,	State, Zip)	Title	Amount			
	2. Other Withdrawings (Specify)	}					
	Purpose	Amount		unt			
	3. Total Deductions						
H.	Balance at End of Period 09/30/19					534,716	

# I. Preparer's/Reviewer's Certification

Name of Facility			License No.		Report for Year Ended	Page o	of	
Universal Healthcare Holdings LLC			2541	9/30/2019	37 3	37		
Check appropriate category								
Ø	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)		(Specify)				
Preparer/Reviewer Certification								
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.								
Signature of Preparer		itle		Date Signed				
Printed Name of Preparer								
iCare Management, LLC								
Addres Address					Phone Number			
341 Bidwell Street, Manchester, CT 06040					860-570-2140			
Contacted Person Regarding Additional Information Needed Regarding This Report					Phone Number			
Contact Email Address								